A Plan to Monitor Healthcare Access for Nevada Medicaid Beneficiaries

Medicaid Fee for Service (FFS) Program:

Methods for Assuring Access to Covered Medicaid Services

Executive Summary

The Nevada Department of Health and Human Services (DHHS) promotes the health and well-being of its residents through the delivery or facilitation of a multitude of essential services to ensure families are strengthened, public health is protected, and individuals achieve their highest level of self-sufficiency. The DHHS is comprised of six Divisions: Aging and Disability Services Division (ADSD), Division of Child and Family Services (DCFS); Division of Health Care Financing and Policy (DHCFP), Division of Public and Behavioral Health (DPBH); Division of Welfare and Supportive Services (DWSS) and the Public Defender.

The DHCFP works in partnership with the Centers for Medicare and Medicaid Services (CMS) to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources. The DHCFP administers Nevada Medicaid and Nevada Check Up.

The DHCFP's framework for developing an Access to Care Monitoring Review Plan (ACMRP) for the fee for service (FFS) Medicaid population receiving services through FFS is adapted from a synthesis of several sources, including the agencies within the U.S. Department of Health and Human Services. The DHCFP framework includes several components:

A. Characteristics of the population
B. Hindering Factors
C. Approach for effective quality to care outcomes
D. Developing Access

The Code of Federal Regulations at 42 CFR 447.203 refers to the requirements for the ACMRP for payment rates and comparisons to the general population. The provision indicates it is necessary for states to compare Medicaid payment rates to the rates of Medicare or private payers. Due to the requirements set forth in Nevada Revised Statue (NRS 686B.080), the information for the rates paid by private payers is considered proprietary and is not subject to disclosure. The DHCFP will monitor, review and assess Medicaid rates and compare those rates to the rates paid by Medicare.

Within the DHCFP framework of the ACMRP measures were selected to provide a comprehensive overview of health care access in Nevada; while taking into account the limitations of available data sources.

The DHCFP has designed a process for monitoring health care access which includes data collection and trend analysis for identification and interpretation of access to care needs not being met. The DHCFP has requested two Management Analyst positions to evaluate rates and funding to work with a contractor to evaluate data trends and provide oversight analysis for the ACMRP. The DHCFP Quality Chief will oversee the tracking of measures and compare with previous studies. Upon the identification of healthcare access problems, the DHCFP will analyze each

measure in conjunction with public input identify processes that need improvement and implement a remediation action plan.

Table of Contents

I. Overview

The mission of the DHCFP is to purchase and provide quality health care services to low-income Nevadans in the most efficient manner possible; promote equal access to health care at an affordable cost to the taxpayers of Nevada; restrain the growth of health care costs; and review Medicaid and other state health programs to maximize potential federal revenue.

The DHCFP is part of DHHS and administers two major health coverage programs which provide health care to Nevadans: (1) Medicaid provides health care to low-income families, as well as aged, blind and disabled individuals. Nevada expanded the Medicaid program to include low-income childless adults effective January 1, 2014 as part of Patient Protection and Affordable Care Act. (2) Nevada Check-Up, Nevada's Children's Health Insurance Program (CHIP) provides health coverage to low-income, uninsured children who are not eligible for Medicaid. Services for both programs are provided on a FFS basis, and through managed care networks.

The evaluation of healthcare access assists the DHCFP in determining if Nevada Medicaid and Check Up programs are positively affecting beneficiaries' health outcomes. Additionally, an access measurement system also serves as an early-warning mechanism for alerting the State to potential deficiencies in accessing Nevada Medicaid services.

The proposed plan identifies an array of access measurement methods and processes. Consistent with Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC) recommended criteria, the access monitoring system presented in this document will take into account: (1) the characteristics and complex health needs of Nevada Medicaid enrollees; (2) the availability of Nevada Medicaid providers; and (3) the appropriate utilization of healthcare. Each of these three key areas provides a comprehensive portrayal of healthcare access for Nevada Medicaid and Check Up beneficiaries. Moving forward, the set of measures identified in this document will be used to track trends and identify access deficiencies in the Nevada Medicaid programs.

II. Beneficiary Population

Nevada's geographical structure as well as the rapid growth in the Medicaid program poses challenges to access to health care. Nevada is made up of 17 counties which include urban, rural and frontier areas. Due to the rural and frontier nature throughout the state, beneficiaries in many instances must choose to seek medical care outside their residential area. Nevada opted to expand the Medicaid population through the Patient Protection and Affordable Care Act (PPACA). This has resulted in the population going from approximately 320,000 beneficiaries in the summer of 2013 to over 600,000 beneficiaries in May 2016. Nevada has two health care delivery models: FFS and managed care. The managed care delivery model currently includes two health plans (Amerigroup and Health Plan of Nevada). Approximately 71% of the combined Medicaid and CHIP population are enrolled in managed care. The 29% receiving care through FFS are comprised of individuals with disabilities, the elderly and all beneficiaries living in rural and frontier areas. See figures 1, 2 and 3 below

Figure 1. Total Medicaid Recipients

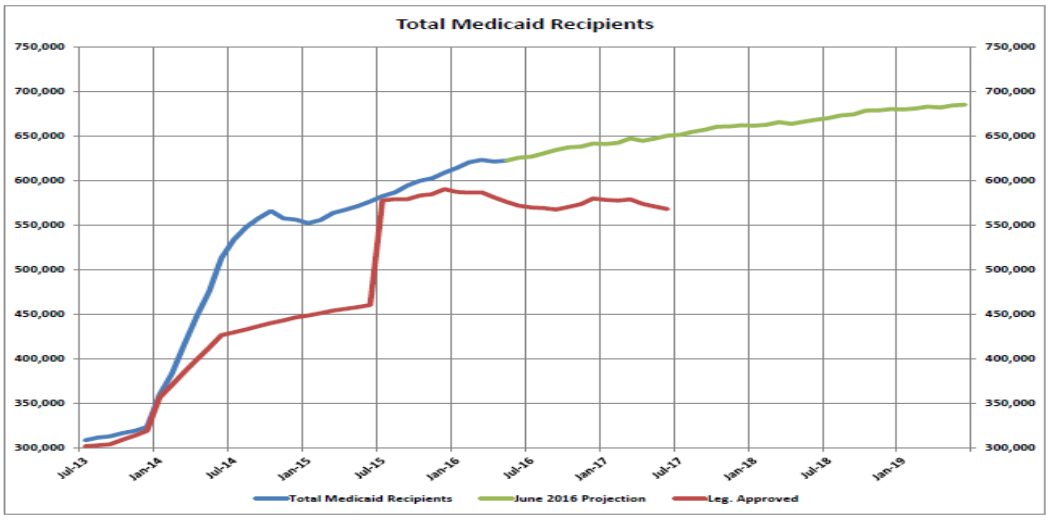


Figure 2. Nevada Check Up

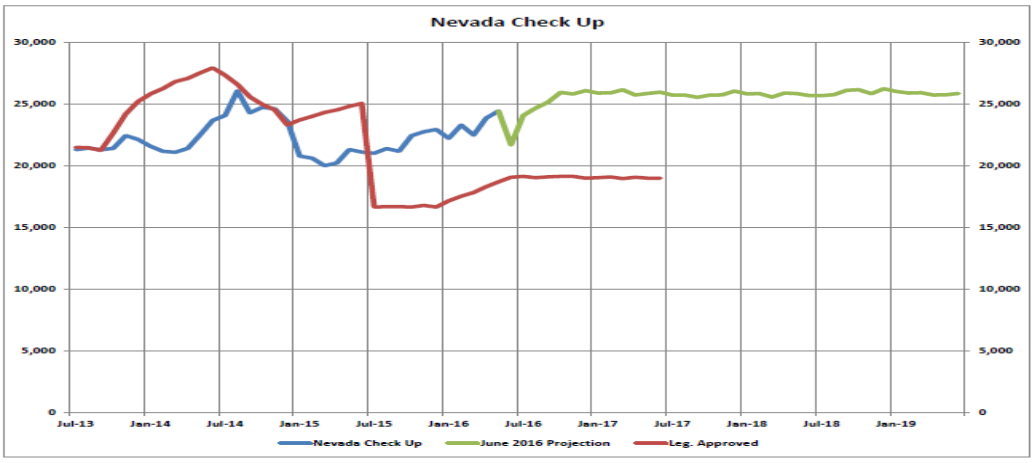
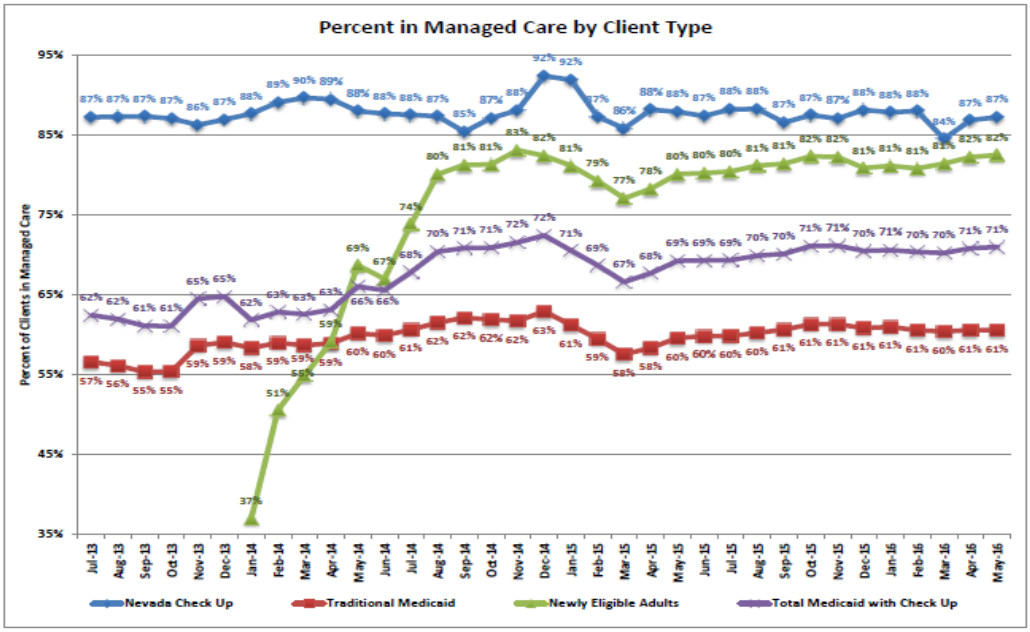


Figure 3. Percent in Managed Care by Client (Beneficiary) Type



III. Access Concerns Raised by Beneficiaries

The State of Nevada currently gathers information from beneficiaries regarding access to care through customer service lines, public workshops and hearings, stakeholder meetings, and through the legislative process. The customer service line is a toll free line, operated through the Medicaid district offices. Customer service representatives (CSR) when requested assist callers to find health care providers. The State holds public workshops and hearings when services are developed or changed to gather public input including provider qualifications and potential access issues.

The DHCFP program staff participates as members and attends stakeholder councils, consortiums, and boards where stakeholders share concerns and develop long term strategic plans. The DHCFP also gathers input through legislative meetings and testimony.

IV. Review of Current Access to Care

In 2015 the DHCFP requested the External Quality Review Organization (EQRO) to conduct an evaluation of Nevada's Medicaid provider network. The purpose of the analysis was to estimate the provider network capacity, geographic distribution, and appointment availability of both the MCO's and FFS networks. The evaluation showed a comparison among three dimensions, by provider type, for each MCO and FFS program relative to the State of Nevada's general population. The analysis consisted of three dimensions of access and availability:

- Capacity
    - Provider to Beneficiary ratio for Nevada provider network
- Geographic Network Distribution
    - Time/Distance analysis for applicable provider specialties and average distance to closest provider
- Appointment Availability
    - Average length of time (number of days) to see a provider for MCOs and FFS

The 2015 study represents one of many ongoing attempts to capture, report, monitor, and explore the experience of Medicaid beneficiaries' access to health care services.

Overall, the result of this analysis, including the provider ratio analysis, the geographic network distribution analysis and the secret shopper survey showed that while the MCOs and FFS have developed comprehensive provider network, opportunities for improvement exist in the implementation of these networks.

While the Medicaid provider network infrastructure is robust, the engagement of providers represents an area for improvement. Across the four categories evaluated in the secret shopper analysis (i.e., PCPs, prenatal care providers, specialists, and dentists), nearly 50 percent of all outreach calls failed to secure appointments (47.6 percent); and of those calls that ended in an appointment, less than three-quarters (69.4 percent) were scheduled within contract standards (see table 1). As such, while the network appears robust regarding the provider infrastructure, access to care is often affected by the ability to schedule appointments. In response to these survey findings, the DHCFP collaborated with both the MCO's together to develop a remediation action plan and the following initiatives are in process.

Table 1. Appointment Availability Results

Specialty Category	Valid Cases	Unable to Schedule Appointment		Able to Schedule Appointment		Appointments within Compliance Standards	
		Number	Percent	Number	Percent	Number	Percent
PCP	208	85	40.9%	123	59.1%	73	59.3%
Prenatal Care							
First and Second Trimester	144	86	59.7%	58	40.3%	14	24.1%
Third Trimester	144	90	62.5%	54	37.5%	10	18.5%
Specialist	288	163	56.6%	125	43.4%	108	86.4%
Dentist	288	86	29.9%	202	70.1%	185	91.6%
Total	**1,072**	**510**	**47.6%**	**562**	**52.4%**	**390**	**69.4%**

Based on the 2015, Network Adequacy Study, both the DHCFP and Managed Care Health plans formed a focus workgroup. The goal of the focus workgroups are to allow for an opportunity to develop an improvement approach instead of a corrective action plan written on paper without results. The purpose behind the improvement approach is to hold each health plan accountable through action.

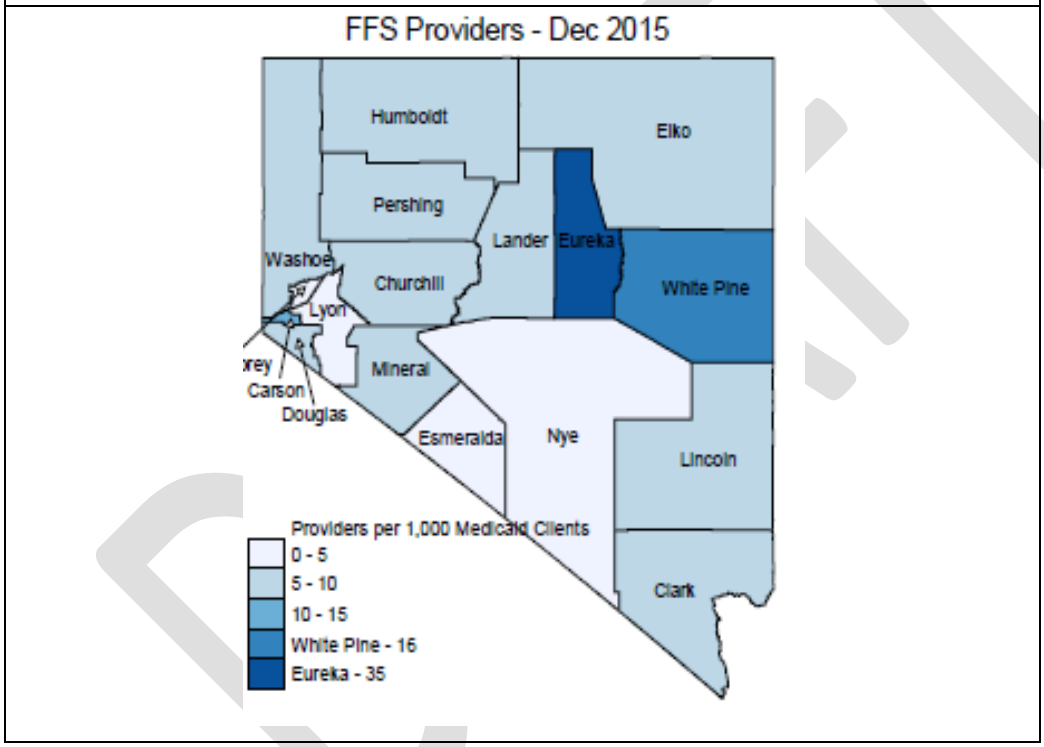
Each plan provided ideas and their plan of action on how Nevada could potentially change the direction of operations and work towards Prevention, Quality of Treatment and Early Intervention in Nevada. In general, the MCOs have developed several approaches to remediating the concerns discussed from the Network Adequacy study of 2015. Such as, outreach mobile units that provide comprehensive exams. Health plans have put nurses into the community providing health services including working with beneficiaries who are homeless living on the streets and under bridges. Each health plan is increasing their provider relations by on-site visits and providing one on one education to provider for billing. Other areas of focus are but not limited to; assisting with Non-Emergency Transportation ride set up, daycare outreach solutions, reaching out to specialist in Nevada, and quicker response time for reimbursements.

V. Nevada Medicaid/Check Up Provider Composition

Below is the geographic mapping of the Nevada FFS providers per 1000 Medicaid recipients:

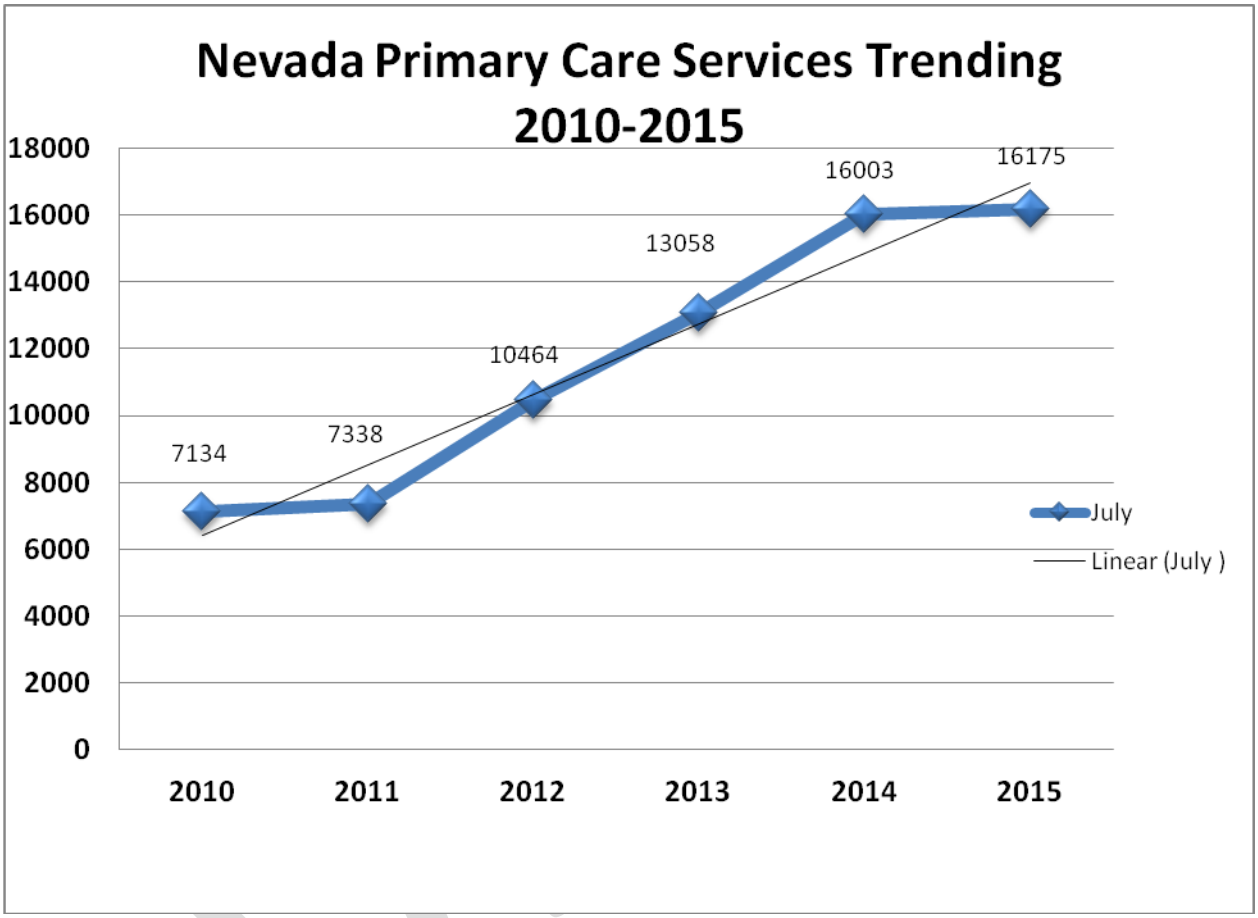
Nevada Department of Health and Human Services, Nevada Data & Key Comparisons

Figure 4. Fee for Service (FFS) Providers

Maps ACA Outcomes by County, continued Source-uninsured-CPS Medicaid totals DWSS ILD file; other DHCFP


In July 2010, we had a total of 7,134 (Primary Care Practitioners/ PCP-Extenders, Specialty Providers, Behavioral Health, Pre and Post-Natal, Home Health and Dental providers enrolled. As of July 2015 we had 16,175 providers enrolled.

Figure. 5 Enrolled Provider Snapshot for year 2010-2015



See Attachment B for the outline of each of the primary core categories of service used as a basis for the projected measure guidelines within the ACMRP, Providers identified by Provider Type and Specialty Code.

VI. Comparison analysis of Nevada Medicaid payment rates to Medicare

The data in the table below shows that for 2015, Nevada's payment rates are approximately 90% of the Medicare non-facility rates and 68% of the Medicare facility rates. By contrast, Utah, Nevada's neighboring state, averaged to 83 % of the Medicare non-facility rates and 86% of the Medicare facility rates. Nevada Medicaid reimburses the same amount for adults and pediatrics.

Due to the requirements set forth in Nevada Revised Statue (NRS 686B.080), an analysis was not performed comparing to other payers. The information for rates is considered proprietary and is not subject to disclosure. The Facility and Non-Facility Rate comparison groups are shown in Attachment A.

Nevada Medicaid recognizes that the large majority of Nevada is made up of rural and frontier areas resulting in scarce providers and services including transportation. Residents living near state lines or borders may be geographically closer to out-of-state providers than in-state providers for all five core areas. Therefore Nevada recognized border catchment areas as in-state providers.

VII. Identified Access Measures

Nevada Medicaid will work collaboratively with the DPBH, the DWSS, and other sister agencies to monitor and review the five core provider types as identified in the access to care regulation including Dentists. Trend analysis will be completed combining information from multiple sources.

a. Review analysis of primary care services:

Data sources: Provider enrollment

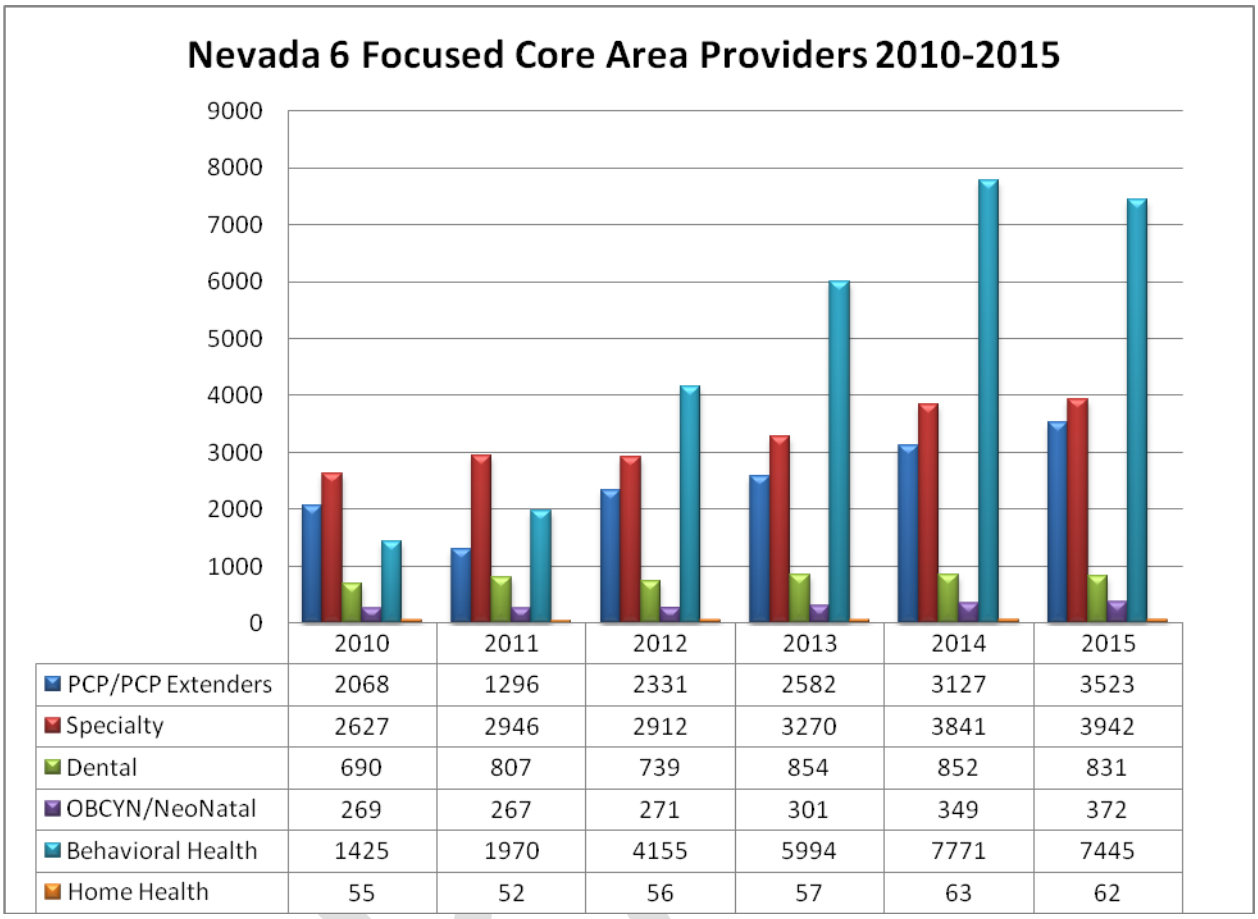
MMIS claims payment

Results of CAHPS-FFS survey will be available upon completion of survey.

Availability of primary care providers:

In 2010, Nevada had a total of 7,134 enrolled providers: which included 2,068 Primary Care Practitioners (PCP)/PCP Extenders, 2,627 Specialty, 690 Dentist, 269 Obstetrician/Neo Natal, 1,425 Behavioral Health, and 55 Home Health providers – trended over time, the state of Nevada in 2015 increased PCP/PCP Extenders to 3,523, , Specialty to 3,942, Dentist to 831, Obstetrician/Neo Natal to 372, Behavioral Health to 7, 445 and Home Health Agencies to 62 providers. Trended over time, the state of Nevada in 2015 increase provider enrollment to 16,175 of the 6 focused Core Area Providers.

Figure.6 July Snapshot of selected provider types year 2010-2015



	2010	2011	2012	2013	2014	2015
PCP/PCP Extenders	2068	1296	2331	2582	3127	3523
Specialty	2627	2946	2912	3270	3841	3942
Dental	690	807	739	854	852	831
OBCYN/NeoNatal	269	267	271	301	349	372
Behavioral Health	1425	1970	4155	5994	7771	7445
Home Health	55	52	56	57	63	62

The Primary Care Needs Assessment of Nevada conducted in 2016 by the Division of Public and Behavioral Health; generated concerns/issues raised by primary care providers were through survey of the Nevada professional licensing boards. Some of the concerns/issues regarding, *"Health insurance was identified as a major concern for all population domains, as a key barrier to health access, in addition to the limited number of providers accepting Medicaid, the high volume of paperwork required for the application process, and lack of transportation…."*

The number of; FQHCs/RHCs/hospital based clinics – trended over time in Nevada went from 28 providers in 2010 to 39 FQHC's/RHCs/hospital based clinics in 2015.

Figure 7. FQHC/RHC/Clinics

Provider Type	Provider Specialty	July-10	July-11	July-12	July-13	July-14	July-15
17-Special Clinics	180, 181	28	31	33	35	38	39

b. Review analysis of physician specialty services:

The DHCFP has established and formatted a plan to evaluate and monitor similar options considered in the managed care programs. Similar to managed care measures are assessed based on whether they are to be calculated as a hybrid and/or administrative measures using appropriate Healthcare Effectiveness Data Information Set (HEDIS) specifications.

The DHCFP will calculate only the administrative rates which are currently being reported by the MCOs (Children and Adolescents' Access to Primary Care Practitioners-**CAP**, Annual Dental Visit-**ADV**, , Follow Up After Hospitalization for Mental Illness-**FUH**, Phase 2 is to conduct a hybrid calculation for all hybrid measures currently being reported by the MCOs (Utilization Well-Care Visits-**AWC**, Well-Child Visits in the First 15 Months of Life-**W15**, Well- Child Visits in the Third, Fourth, Fifth and Sixth Years of Life-**W34**, Prenatal and Postpartum Care-**PPC**, Frequency of Ongoing Prenatal Care-**FPC**,. Hybrid calculation includes medical record procurement from FFS providers and medical record review to generate the hybrid rate.

Nevada will also calculate PPC, FUH measures using the CMS Adult Core Specifications for FFS only and separately calculate PPC, , and FUH using the CMS Adult Core Specifications for a statewide rate (combined FFS and managed care.)

VIII. Outline of Measure Indicators

The ACMRP outlines and describes the data that will be measured, how baseline data will be established, and thresholds used to monitor sustained access. The plan considers: the availability of Medicaid providers, utilization of Medicaid services and verifies that Medicaid beneficiaries' healthcare needs are met. The identifiable FFS measurable access indicators include:

a. Provider Availability

Measure #1: Population to Primary Care Provider Ratio Ratios

Description: Number of Medicaid Beneficiaries divided by the Primary Care Physician providers, stratified by age, gender, health care location.

Rationale: Since the implementation of the ACA, it has been recognized that provider availability has increased the need for access to care for Medicaid beneficiaries. This measure will allow DHCFP to monitor the availability of Primary care Physician/Physician Assistant. This measure has gained strength at the Federal level and has become a leading concern in monitoring access to care. Data can be reviewed on a quarterly basis for trend analysis regarding Primary Care Physician/Practitioners through administrative data.

Data Source: Medicaid MMIS and DSS paid claims by date of service.
*Excluding all voids.

Frequency of Reporting: Quarterly

Measure #2: Population to Behavioral Health Provider Ratios

Description: Number of Medicaid Behavioral Health beneficiaries divided by the number of active Behavioral Health providers, stratified by age, gender, health care setting and location; excludes beneficiaries with limited benefits.

Rationale: It has been recognized that provider availability is an important aspect when assessing health care for the increasing number of Medicaid beneficiaries. This measure will allow DHCFP to monitor provider availability and to meet important beneficiary sub-category population needs. This measure has gained strength at the Federal level and has become one of the required trending concerns in monitoring access to care. Trends in provider availability can be reviewed on a quarterly basis using administrative data readily available through Medicaid program.

Data Source: Medicaid MMIS and DSS paid claims by date of service.

Frequency of Reporting: Quarterly

Measure #3: Population to Obstetrician (OB) Provider Ratios

Description: Number of pregnant Medicaid beneficiaries, divided by the number of active OB providers, stratified by age, gender, health care setting and location.

Rationale: It has been recognized that provider availability is an important aspect when assessing health care for the increasing number of Medicaid beneficiaries. Prenatal care can lead to healthier newborns. This measure will allow DHCFP to monitor provider availability to meet important beneficiary sub-category population needs. This measure has gained strength at the Federal level and has become one of the required trending concerns in monitoring access to care. Data can be reviewed on a quarterly basis for trend analysis in provider availability through administrative data.

Data Source: Medicaid MMIS and DSS paid claims by date of service.

Frequency of Reporting: Quarterly

Measure #4: Provider Participation Rates

Description: Number of active providers who submitted a claim for services during the period of measurement, divided by the number of active Medicaid providers enrolled in the program, stratified by provider type, healthcare settings and location. Provider types include physicians, physician groups, physician assistant, nurse practitioners, FQHCs, and other clinics.

Rationale: The methodology for evaluating that sufficient number of providers available are available to Medicaid populations focuses on two areas; overall provider service deliveries and provider participation rates in the Medicaid program. According to physician survey research, low Medicaid rates and high administrative burdens are major reasons for providers not accepting Medicaid patients. This measure will allow DHCFP to monitor provider participation rates by provider type and healthcare setting. Based on the new CMS ruling, any decrease in provider participation rates will serve as a trigger for DHCFP to further investigate whether the Medicaid provider network is sufficient to meet enrollee's needs. Trends in increased/decreased provider participation can be reviewed on a quarterly basis using administrative data readily available through Medicaid program.

Data Source: Medicaid Eligibility MMIS System Extract File.

Frequency of Reporting: Quarterly

Measure #5: Population to Dental Provider Ratios

Description: Number of Medicaid Dental beneficiaries under twenty-one (21), divided by the number of active dental providers, stratified by age, gender, health care setting and location. Exclude adult beneficiaries and those with limited benefits.

Rationale: It has been recognized that provider availability is an important aspect when assessing health care with the increasing number of Medicaid beneficiaries. This measure will allow DHCFP to monitor provider availability and availability to important beneficiary sub-category population needs. This measure has gained strength at the Federal level and has become one of the require trending concerns in monitoring access to care. Data can be review on a quarterly basis for trend analysis in provider availability through administrative data.

Data Source: Medicaid MMIS and DSS paid claims by date of service.

Frequency of Reporting: Quarterly

b. Service Use Results

Measure #6: Percent of Enrollees with at least one Provider Visit during the past 12 months

Description: The number of Medicaid beneficiaries who had at least one provider visit within the past year, divided by the total number of Medicaid beneficiaries continuously enrolled during the measure period, stratified by age, gender, eligibility category, healthcare setting and geographical location. Physician visits include physicians, physician groups, physician assistant, nurse practitioners, FQHCs, and other clinics.

Rationale: Preventative health services have been linked to the benefits of seeing your primary care provider (PCP) annually and better management of chronic disease. This measure will allow DHCFP to monitor annual contact with providers among Medicaid beneficiaries. This measure has also been recognized as one of several core measures incorporated in the CMS-Childern's Health Insurance Program Reauthorization Act (CHIPRA) access and quality measures and incorporated in HEDIS measures. Trends in physician visits can be identified and evaluated using administrative data readily available through the Medicaid program.

Data Source: Medicaid MMIS claims/ encounter data

Frequency of Reporting: Quarterly

Measure #7: Medicaid Beneficiary Perceived timely Access to Care-CAHPS

Description: Number of survey respondents who answer affirmatively to the questions, **"Getting Care Quickly" and "Getting Needed Care"** divided by all survey respondents including non-missing (unanswered) answers to these questions, stratified by gender, age and geographic location.

Rationale: A delay in receiving necessary medical services leads to a delay in diagnosing and treating acute and chronic conditions can potentially increase in disease severity and also lead to high cost health care utilization such as visits to the emergency room. Untimely access to services is one of the many signs of the problematic areas within the health care delivery system. Currently, the CAHPS survey is issued to our managed care population, but not the FFS population. This measure will allow the DHCFP to monitor perceived timely access to services among Medicaid beneficiaries. This measure has been used in data collection for the managed care organizations. Data can be evaluated and trends identified in timely access to care as perceived by Medicaid Beneficiaries through the Medicaid CAHPS Survey.

Data Source: CAHPS

Frequency of Reporting: Annually

Measure #8: Home Health Provider Ratios

Description: Number of Home Health Agencies enrolled with Nevada Medicaid divided by the total number of licensed Home Health Agencies, stratified by county.

Rationale: Access to care in rural and frontier communities can be limited. While Nevada Medicaid may not have the ability to attract home health agencies to these communities, it does have the ability to encourage existing home health agencies not already enrolled with Nevada Medicaid to do so.

Data Source: Total number of licensed home health agencies: Department of Health and Human Services Division of Public and Behavioral Health on-line Licensee Search database.
Number of home health agencies enrolled with Nevada Medicaid: Department of Health and Human Services Division of Health Care Financing and Policy Provider Support Dashboard.

Frequency of Reporting: Annually

IX. Remediation Action Plan

The DHCFP's monitoring activities consist of two main components: (1) monitoring and evaluating throughout the year to identify early indications of changes in health care access, and (2) developing a remediation action plan to address the lack of healthcare in a particular area of service. Remedial actions may include policy revision, process simplifications, rate adjustment and/or enhanced provider outreach.

Nevada Medicaid will use the Plan Do Study Act (PDSA) model in quality improvement initiatives. The model incorporates the idea of continuous quality improvement through a process and problem solving approach. The continuous quality improvement process will monitor access to care, timeliness, quality of care and operational performance; identify opportunities for improvement that exist throughout the Nevada Medicaid program; implement intervention strategies to improve outcomes and performance; evaluate interventions to determine successfulness; and reassess performance through re-measurement to identify new opportunities for improvement.

Nevada currently reviews any rate changes to identify impact on access to care.

The DHCFP plans to put the monitoring procedures in place and evaluate for process improvement on an annual basis. The discovered outcomes and revised analysis will be reported to CMS at least every three years. Based on remediation requirements per CMS direction to this plan, the DHCFP will also update this plan on a case-by-case rate change basis whenever a new State Plan Amendment (SPA) change has been requested for authorization of payment changes.

A. CAHPS for Fee for Service population

Adult Medicaid CAHPS, Child Medicaid and Nevada Check Up Medicaid CAHPS

	Health Plan A	**Health Plan B**	**FFS**
Composite Measures			
Getting Needed Care			
Getting Care Quickly			

1. A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result, otherwise denoted as N/A.
2. The NCQA CAHPS Medicaid national averages are to be used for internal analysis only and cannot be displayed publicly.

B. New Measure: Customer Service/Help Line Calls Documented by Reason

Description: The number of Help Line calls received during the reporting period, stratified by location and reason of call.

Rationale: The DHCFP has established and will be implementing a Medicaid Help Line to address gaps in beneficiary informational data. The Medicaid Help Line will be similar to the DWSS and the managed care customer service line. Beneficiary calls into the newly developed Help Line will capture data pertaining to the reason for the call and location of the beneficiary. A trend analysis on the reason for the call and location will provide further understanding of what types of gaps in need exist for Nevada Medicaid enrollees and where the needs exist.

Data Source: Data will be provided by the current call center tool.
Frequency of Reporting: Quarterly

In conclusion, as the healthcare access monitoring review program evolves in Nevada, it is envisioned that refinements and remediation to the initial set of measures will occur.

X. Resources & Link to Nevada Reports

1. Nevada Department of Health and Human Services (DHHS) Fact Book, February 2016

   URL:http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Reports/DHHS_FactBook.pdf

2. Nevada Division of Health Care Financing and Policy, External Quality Review-Technical Report SFY 2014-2015, Health Services Advisory Group, October 2015. URL: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/2014-2015%20Network%20Adequacy%20Report.pdf

Attachment A. Facility & Non-Facility Rate Comparison

Procedure Code & Description		Nevada Medicaid Rates	2015 Medicare Non-Facility Rates for NV	% Difference	2015 Medicare Facility Rates for NV	% Difference	Utah Medicaid Rates	2015 Medicare Non-Facility Rates for Utah	% Difference	2015 Medicare Facility Utah	% Difference
59400	PB care antepartum vag dllvr & postpartum	$2,144.73	$2,197.27	98%	$2,198.27	98%	$2,028.50	$2,144.92	95%	$2,144.92	95%
59409	Vaginal delivery only	$840.57	$856.79	98%	$856.79	98%	$802.83	$847.98	95%	$847.98	95%
59510	OB antepartum care cesarean dlvr & postpartum	$1,070.75	$1,093.12	98%	$1,093.12	98%	$2,028.50	$2,385.12	85%	$2,385.12	85%
59514	Cesarean delivery only	$945.68	$962.20	98%	$962.20	98%	$802.83	$956.64	84%	$956.64	84%
71010	Chest x-ray 1 vew frontal	$25.01	$23.35	107%	$23.35	107%	$18.38	$21.48	86%	$21.48	86%
72148	MRI spinal canal lumbar w/o contrast material	$256.98	$231.40	111%	$231.40	111%	$357.49	$212.00	169%	$212.00	169%
73580	Contrast x-ray of knee joint	$135.50	$120.17	113%	$120.17	113%	$84.64	$108.91	78%	$108.91	78%
73615	Contrast x-ray of ankle	$110.16	$102.43	108%	$102.43	108%	$71.98	$98.92	73%	$98.92	73%
73718	MRI lower extremity w/o dye	$389.09	$382.10	102%	$382.10	102%	$584.59	$343.02	170%	$343.02	170%
76380	Cat scan follow-up study	$159.57	$152.50	105%	$152.50	105%	$122.57	$139.36	88%	$139.36	88%
76811	OB us detailed single fetus	$194.09	$190.90	102%	$190.90	102%	$212.39	$177.57	120%	$177.57	120%
77056	Mammogram both breasts	$120.87	$120.33	100%	$120.33	100%	$75.70	$109.92	69%	$109.92	69%
77077	Joint survey single view	$42.57	$39.25	108%	$39.25	108%	$26.77	$35.79	75%	$35.79	75%

Procedure Code & Description		Nevada Medicaid Rates	2015 Medicare Non-Facility Rates for NV	% Difference	2015 Medicare Facility Rates for NV	% Difference	Utah Medicaid Rates	2015 Medicare Non-Facility Rates for Utah	% Difference	2015 Medicare Facility Utah	% Difference
78102	Bone marrow imaging ltd	$181.21	$184.47	98%	$184.47	98%	$70.64	$165.14	43%	$165.14	43%
78300	Bone imaging limited area	$193.92	$195.99	99%	$195.99	99%	$84.44	$176.32	48%	$176.32	48%
78452	Myocardial spect multiple studies	$510.26	$513.30	99%	$513.30	99%	$336.23	$460.24	73%	$460.24	73%
90472	IM Admin PRQ ID subq/IM NJXS Each vaccine	$11.01	$12.89	85%	$12.89	85%	$13.81	$12.06	115%	$12.06	115%
90791	Psychiatric diagnostic evaluation	$155.38	$132.20	118%	$128.06	121%	$33.16	$131.49	25%	$127.53	26%
90792	Psychiatric diagnostic eval w/medical services	$124.29	$146.84	85%	$142.70	87%	$33.16	$145.37	23%	$141.37	23%
90834	Psychotherapy patient &/family 45 minutes	$73.93	$86.43	86%	$85.68	86%	$97.06	$84.77	114%	$84.44	115%
90837	Psychotherapy patient &/Family 60 minutes	$110.56	$128.60	86%	$127.30	87%	$120.79	$127.53	95%	$126.54	95%
90847	Family psychotherapy w/patient present	$92.40	$107.81	86%	$107.06	86%	$27.19	$106.48	26%	$105.82	26%
93306	Echo TTHRC R-T 2D w/WOM-mode compl spec & colr D	$203.53	$238.87	85%	$238.87	85%	$173.58	$216.51	80%	$216.51	80%
99204	Office outpatient visit, new 45 min	$153.96	$169.69	91%	$133.19	116%	$120.63	$161.91	75%	$129.88	93%

Procedure Code & Description		Nevada Medicaid Rates	2015 Medicare Non-Facility Rates for NV	% Difference	2015 Medicare Facility Rates for NV	% Difference	Utah Medicaid Rates	2015 Medicare Non-Facility Rates for Utah	% Difference	2015 Medicare Facility Utah	% Difference
99214	Office outpatient visit, est 25 min	$99.93	$110.56	90%	$80.08	125%	$85.39	$104.77	81%	$78.03	109%
99215	Office outpatient visit est 40 min	$133.61	$149.64	89%	$114.27	117%	$114.84	$141.58	81%	$110.55	104%
	Total Average Comparison			98%		102%			83%		86%

The current Medicare Physician Fee Schedule does not price the following HCPCS codes for Home Health services. The information below provides a sample comparison of Nevada Medicaid rates to Utah Medicaid rates:

Procedure Code & Description		Nevada Medicaid Rates	Utah Medicaid Rates
G0299	Direct skilled nursing services of a RN	$11.87	$22.72
G0300	Direct skilled nursing services of a LPN	$8.84	$17.72
G0151	Services performed by a qualified physical therapist	$14.03	$19.83
G0153	Services performed by a qualified speech-language pathologist	$14.03	$17.97

Medicare does not cover most dental. The table below provides a sample comparison of Nevada Medicaid rates to Utah Medicaid Rates:

Procedure Code & Description		Nevada Medicaid Rates	Utah Medicaid Rates
D0140	Limited oral evaluation-problem-focused	$33.24	$23.11
D0220	Intraoral first dadiograph-periapical	$18.86	$11.55
D0230	Intraoral radiograph-perapical-each addl imag	$5.89	$8.97
D0274	Bitewings-four radiographic images	$23.57	$29.51
D1120	Dental prophylxis-child	$57.28	$32.07
D5110	Complete dentury-maxillary	$615.00	$604.53
D5214	Mand part denture-cast metal frane w/resin bases	$615.00	$646.70
D7210	Surg removal erupted tooth req removal bone	$87.12	$78.27

Attachment B. Provider Table

Identifiers	Provider Type	Provider Specialty	July-10	July-11	July-12	July-13	July-14	July-15
PCP/PCP Extenders	17-Special Clinics	180, 181	28	31	33	35	38	39
	20-Physician	053, 056, 060, 139,148	1380	548	1512	1647	1950	2080
	24-APRN	N/A	303	352	399	449	609	805
	77-PA/PA-C	N/A	357	365	387	451	530	599
Specialty	20-Physician	57, 58, 59, 61, 64, 65, 66, 68, 72, 73, 74, 92, 100, 101, 103, 104, 106, 107, 108, 110, 112, 114, 116, 118, 119, 120, 121, 122, 123, 125, 126, 127, 128, 130, 131, 132, 133, 134, 135, 136, 137, 138, 140, 141, 142, 143, 144, 149, 150, 151, 152, 153, 154, 156, 157, 158, 159, 170, 218	1770	2021	1952	2209	2551	2566
	25-Optometrist		241	261	278	296	339	360
	34-Therapy	027, 028, 029,176, 219	579	617	633	702	875	937
	41-Optician, Optical Business		9	18	12	15	16	13
	76-Audiologist		28	29	37	48	60	66
Dental	22-Dentist	N/A	690	807	739	854	852	831
OBGYN/NeoNatal	20-Physician	062, 067,117, 124, 129, 145	261	263	267	294	341	358
	74- Nurse Midwife	N/A	8	4	4	7	8	14
Behavioral Health	13-Psychiatric Hospital, Inpatient	N/A	10	10	11	11	12	12
	14- Behavioral Health Outpatient Treatment	N/A	616	1142	3258	4697	6141	5893
	20-Physician	113, 146, 147,	86	100	100	120	154	162
	26-Psychologist	N/A	138	150	160	154	175	193
	63-Residential Treatment Center	N/A	3	3	3	3	3	4
	82-Behavioral Health Rehabilitative Treatment	N/A	572	565	623	1009	1286	1181
Home Health	29-Home Health Agency	N/A	55	52	56	57	63	62